PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445216	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINTREE MANOR	415 PACE STREET MC MINNVILLE, TN 37110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: (1) NFPA 80, 3-1.4 (1999 Edition) Operation of Doors. The doors shall swing easily and freely on their hinges. The latches shall operate freely. (2) NFPA 221, 5.1.2* (2000 Edition) Fire walls having a required fire resistance rating of 4 hours shall have each opening protected with a minimum 3-hour fire resistance rating. Based on observations, the facility failed to comply with the Life Safety Code. The findings included: 1. Observation on 06/07/2016 at 11:00 AM, revealed the cross corridor fire doors by room 511 and room 212 did not latch within the frame. NFPA 101, 4.4.2.1 (2000 Edition) NFPA 101, 8.2.3.2.1 (2000 Edition) NFPA 80,3-1.4 (1999 Edition) 2. Observation on 06/07/2016 at 11:02 AM, revealed the fire doors in the 4 hour fire wall by room 212 were 1 ½ hour rated. NFPA 101, 4.4.2.1 (2000 Edition) NFPA 101, 8.2.2.2 (2000 Edition) NFPA 221, 5.1.2 (2000 Edition) These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 06/07/2016	K 130	K130 1) inspection of other fire doors found 1 other set of fire doors not to be in compliance. 2) All residents have the potential to be affected by this practice 3) Specifications for replacement doors were emailed to Colby Henson on 6/23/2016 for approval. Both sets of Fire Doors will be replaced and were ordered on 6/29/2016. 4) During fire drills, doors will be inspected each month for 3 months during fire to ensure they are latching properly. Findings will be and report any issues to the Quality Assurance Performance Improvement Committee consisting of The Administrator, Director	7/23/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6/29/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		K 130	of Nursing, Quality Assurance Nurse, Social Services, MDS Coordinator, Medical Records Director, Business Office Manager, Human Resources, Dietician, Maintenance Director, Admissions Coordinator and the Medical Director monthly for 3 months or until 100% compliance is achieved.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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